TRICARE PRIME REMOTE (TPR)
IMPLEMENTATION INSTRUCTIONS

I. General

Under the TRICARE Prime Remote (TPR) Program, the TRICARE Managed Care Support Contractors (MCSC) will enroll Active Duty Service Members (ADSMs) and process claims for civilian health care services received by ADSMs assigned to work units in remote locations. Enrollment is mandatory for all active duty service members who qualify for the TRICARE Prime Remote program. The Military Services retain control over the source of ADSMs' health care, based on "fitness for duty" considerations. Service Points of Contact (SPOCs) will be assigned by the Services to the Military Medical Support Offices (MMSO) at Great Lakes, IL to provide the necessary oversight. MCSC's responsibilities and instructions are located in the TRICARE Operations Manual, Part Three, Chapter 8.

II. TRICARE Prime Remote Service Areas

A. TRICARE Prime Remote (TPR) service areas are defined as those being located more than 50 miles or more than a one hours' drive from a military medical treatment facility (MTF) designated as adequate to provide the needed primary care services to the ADSM. ADSMs must live and work in a TPR service area. Lead Agents are responsible for maintaining and updating (as necessary) the zip code listings that define the TPR service areas.

B. The Lead Agent will provide the MCSC with a list of zip codes detailing the TPR service areas. These zip codes will be determined based on input from the Services regarding which MTFs have the capacity to deliver primary care services to the active duty population within a 50-mile radius.

C. Following establishment of TPR service areas, in unique situations where geographic barriers exist, a unit or individual, with the permission of the unit commander, may request an eligibility waiver from the Lead Agent. The Lead Agent will review the request and forward it, along with a recommendation to approve or disapprove the waiver, to the Chief Operating Officer, TRICARE Management Activity (TMA). TMA will notify the Lead Agent of the decision. The Lead Agent will notify the Service unit of the decision, and if approved, will also notify the MCSC.

III. Enrollment

A. Enrollment is mandatory for all active duty service members residing in a designated TPR service area. MCSCs will complete the enrollment transaction using regional Composite Health Care System (CHCS) hosts.

B. United States Coast Guard (USCG) personnel stationed in units designated as geographically separated by the USCG, will enroll in the TPR Program. Exemptions to

this requirement will be granted by the respective USCG Service Point of Contact (SPOC) listed in Attachment 1.

C. Enrollment to a Network PCM. For those TPR areas where the MCSC has already established a PCM network, the ADSM should select a PCM from the contractor's provider directory. If the ADSM does not select a PCM, the contractor will assign one at the time of enrollment. ADSMs may request a change in PCM at any time. Changes will be accommodated to the extent that other network providers are available—or to a non-network provider if circumstances support that decision.

D. Enrollment Where No Network PCM Is Available. In areas where no PCM network is available, the ADSM must enroll and will be allowed to select any TRICARE-authorized provider in the area.

E. The completed and signed enrollment application should be submitted to the MCSC as soon as the ADSM reports to the remote unit, but no later than thirty (30) days after reporting to the remote unit.

IV. Care Authorization and Appeals

A. Primary Care. ADSMs enrolled in TPR do not require preauthorization for primary or preventive care. ADSMs may make appointments directly with their PCM or primary provider for these services. ADSMs with an assigned PCM should first seek care with their PCM. The chart on the following page provides some general guidance on what services do and do not require preauthorization. These guidelines are intended as a sampling of treatment situations. These guidelines are not all-inclusive and are provided to help determine what types of health care services require a fitness-for-duty review by the service point of contact (SPOC). ADSMs are encouraged to contact the HCF any time they have a question about health care services, procedures for receiving care, and filing claims. Providers and Health Care Finders (HCFs) are encouraged to contact the MMSO/SPOC in specific situations for information and clarification on health care for ADSMs. The contractor shall conduct the Prime medical necessity reviews as required by the contract.

Health Care Service	**SPOC Review Required**	**"Where is Care Provided?"**
Primary care medical services	No	PCM (or TRICARE authorized Civilian Provider) or MTF
Emergency/Urgent consults and tests required within 48 hours	Yes, but care will not be delayed while waiting for SPOC response. Follow-up specialty care requires SPOC review.	TRICARE–authorized Civilian Provider TRICARE-authorized Civilian Provider if approved by SPOC or MTF

Periodic health assessments offered under Prime enhanced benefit	No	PCM (or TRICARE-authorized Civilian Provider), or MTF
Periodic eye and hearing examinations	No	TRICARE-authorized Civilian Provider or MTF
Eye glasses/contacts	Yes	MTF or Service Labs; SPOC will provide information to ADSM
Annual GYN/Pap exam	No SPOC to review on follow-up visit	PCM (or TRICARE-authorized Civilian Provider), or MTF PCM (or TRICARE-authorized Civilian Provider if approved by SPOC), or MTF
Service specific physical exams (for DoD/Service forms)	Yes	TRICARE-authorized Civilian Provider or MTF as designated by SPOC
HIV testing incidental to an episode of care	No	PCM (or TRICARE-authorized Civilian Provider)
Maternity Care Routine: Complicated pregnancies:	1st OB visit requires SPOC review: Routine OB follow-up visits and clinically indicated evaluations not related to complications (such as ultrasounds done for dating determinations) do not require SPOC review Care for complications of pregnancy, including care that requires invasive procedures or hospitalization(s) require SPOC review	TRICARE-authorized Civilian Provider
Hearing Appliances	Yes	MTF; SPOC will provide information to ADSM
Orthotics	Yes	TRICARE-authorized Civilian Provider
Physical Therapy	Yes	TRICARE-authorized Civilian Provider
Service-required immunizations	No	PCM (or TRICARE-authorized Civilian Provider), or MTF
Routine dental care and dental procedures	Forward claims and inquiries to SPOC	Civilian dentist or VA (SPOC processes and pays claims)
Counseling by a marriage & family therapist	Yes	TRICARE-authorized Civilian Provider

Mental health counseling, psychiatric care and testing	Yes	TRICARE-authorized Civilian Provider or MTF
Invasive surgical-medical procedures – inpatient/outpatient, non-emergency	Yes	TRICARE-authorized Civilian Provider or MTF as designated by SPOC
Family planning (tubal ligation/vasectomy)	Yes	TRICARE-authorized Civilian Provider or MTF as designated by SPOC
Infertility evaluation	No Yes (for follow-up specialty care/surgery)	PCM (or TRICARE-authorized Civilian Provider) TRICARE-authorized Civilian Provider or MTF as designated by SPOC
Drug, alcohol & follow-on care for substance abuse	Yes	TRICARE-authorized Civilian Provider or MTF if designated by SPOC
Transplants	Yes	STS (or authorized Civilian Transplant Center if STS not available)
Experimental protocols, as allowed by the Uniform Benefit	Yes	TRICARE-authorized Civilian Provider or MTF as designated by SPOC
Specialty dental care (crowns, bridges, endodontics, etc.)	Forward claims and inquiries to SPOC	Civilian dentist or VA (SPOC processes and pays claims)
Ambulatory Surgery or Inpatient care	Yes	TRICARE-authorized Civilian Provider or MTF as designated by SPOC

B. Specialty Care. If the PCM refers the ADSM to a specialist, the PCM should contact the HCF to ensure an authorization is entered on the contractor's system. If an ADSM has no assigned PCM and receives care from another provider, the ADSM is responsible for contacting the HCF for a specialty care authorization. The HCF performs a medical necessity review as required by the regional managed care support contract. A flow chart depicting the specialty care review and appeals process is provided at Attachment 2.

1. If the requested service is deemed medically necessary (via utilization of established criteria sets, e.g., Milliman and Robertson), the HCF transmits information to MMSO.

2. If the requested service is deemed not medically necessary (via utilization of established criteria sets, e.g., Milliman and Robertson), and the service is listed in OPM Part Three, Chapter 8, Addendum B, the HCF will transmit the information to MMSO for their fitness-for-duty determination. At no time will the MCSC deny care based upon medical necessity.

3. MMSO will perform a review of services to be delivered and determine if fitness-for-duty is an issue, and therefore requires referral to a MTF. If there is no fitness-for-duty issue, MMSO approves the services and notifies the HCF. MMSO has two business days in which to render a decision. Should two business days pass and no decision is made, it is assumed that the care requested does not require referral to a MTF. The HCF will then enter the proper authorizations into the claims payment system.

4. If there is a fitness-for-duty issue, MMSO notifies the HCF of the requirement for military medical review. The HCF will notify the ADSM and assist with a referral to the nearest MTF with appropriate capability. MMSO will also notify the ADSM or his/her unit commander that the request for civilian health care services has been disapproved and direct the patient to a military MTF.

5. If the ADSM does not have a network PCM, the member should contact the HCF before receiving any non-emergency health care services to ensure that an authorization is entered, if required, and that the SPOC is notified, if necessary.

C. Medical Care Appeals.

1. Disapproved Requests for Civilian Health Care. All appeals for disapproved requests for civilian care will be sent to the SPOC. If the appeal is disapproved, the SPOC will notify, in writing, the MCSC (e.g., via the HCF), and the ADSMs unit commander. ADSMs may make a final appeal to their respective Service Surgeon General.

2. Disapproved Services. For health care services that are not benefits under TRICARE, if the SPOC disapproves a claim or request for specialty care, the SPOC will notify, in writing, the MCSC (e.g., via the HCF), and the ADSMs unit commander. The MCSC shall refer all inquiries related to the approval or disapproval of requested care to the SPOC, and the SPOC shall inform the ADSM of appeal procedures. ADSMs may make a final appeal to their respective Service Surgeon General.

3. Disapproved Medical Claims: The MCSC shall issue an Explanation of Benefits (EOB) to the ADSM for all claims submitted. When the SPOC has denied authorization for the care listed on the claim, the EOB shall include a reason code for the denial and specific information for filing an appeal with the appropriate SPOC. In the event an appeal reverses the decision and care is approved, both the ADSM and HCF will be notified of the approval by MMSO.

D. MMSO Authority. The MMSO will have the authority to make decisions regarding claims payment on any beneficiary under the TPR program, and may direct the contractors to pay claims when payment is in question or dispute. The MMSO will notify the MCSCs of any decisions to overturn or otherwise direct payment of claim. The MCSCs will subsequently notify their subcontractors (claims processors) of such decisions.

E. Filing Medical Care Claims.

1. Provider-Filed Claims. Once authorized care is received, the provider should file the claim with the claims processing contractor for the region in which the member is enrolled.

2. Beneficiary-Filed Claims. In some instances, a provider may refuse to file claims on behalf of a beneficiary. If the provider will not file the claim, the ADSM must submit an itemized bill along with a completed and signed DD Form 2642, CHAMPUS Claim (available on the TRICARE web site: http://tricare.osd.mil/ClaimForms). The ADSM is responsible for paying any medical bill for which the member files a claim and receives payment. If the provider requires payment from the member for more than the CHAMPUS Maximum Allowable Charge (CMAC), the contractor will reimburse the member the full out-of-pocket cost incurred. Service members will not incur any deductibles or copayments under this program.

V. Dental Care

A. Background.

1. Service members must be enrolled in TRICARE Prime Remote to be eligible for the dental benefits described below in Section B. Further guidance should be obtained from MMSO or the Reserve unit or National Guard medical representative.

2. MMSO will serve as the centralized Armed Forces case management office for dental care in TPR, and the claims processor for all civilian ADSM dental claims throughout CONUS.

3. MMSO will pay civilian dental claims for all Army, Air Force, Navy, Marine Corps, Coast Guard and Army or Air National Guard ADSMs beginning 1 October 1999. The dental program will include the preauthorization of requests for dental treatment, education and liaison with GSUs, civilian dentists, and VA dental clinics.

4. In addition to paying for care from civilian dentists, MMSO also maintains agreements with VA facilities nationwide, many of which provide dental care in varying degrees (A current listing is available from the MMSO web site).

5. The Drilling members of the Reserve components, Army or Air National Guard, and students enrolled in the Reserve Officers Training Program are not eligible for routine dental care under this program. Eligibility for Drilling members of the Reserve Component is limited to specifically approved treatment of service connected injuries only, and is covered under the Supplemental Health Care Program instruction.

B. Procedures for Obtaining Dental Care.

1. Emergency Dental Treatment. Emergency care does not require preauthorization. It is defined as the immediate treatment, including prescription medication, required to relieve pain or prevent serious infection or loss of tooth structure. The ADSM may seek emergency dental care from any licensed dentist. Following treatment of the emergent condition, any subsequent appointments do require prior approval if they exceed amounts or criteria discussed below.

2. Routine Dental Treatment. In some areas, agreements exist between the VAMC and MMSO, by which the VA dental clinic agrees to treat ADSMs and are reimbursed directly by MMSO. Where such an agreement exists, ADSMs must use the VA clinic for routine care. A listing by state of these VA facilities is available on the MMSO web page (http://navymedicine.med.navy.mil/mmso). MMSO or the VA clinic may also be contacted for specific information about access to care. Otherwise, ADSMs are authorized to obtain routine dental care from any licensed dentist without first obtaining prior approval, providing the treatment meets all of the following requirements.

(a) Routine dental treatment includes diagnostic (exams, x-rays, etc.) preventive procedures (temporary fillings, cleanings, and periodontal scaling), routine restorations (amalgams or composite fillings), extractions, root canal treatments, and minor periodontal treatment (e.g., root planing and curettage).

(b) Only procedures that are less than $500 per treatment episode are considered routine. For example, extractions are covered primarily for the removal of diseased and nonrestorable teeth. However, the surgical removal of four wisdom teeth would normally exceed the allowed amount, and therefore requires prior approval.

(c) Treatment plans that exceed a total of $1500 per calendar year require preauthorization, even if all of the treatments individually meet the definition of routine care.

3. Specialty Treatment.

(a) Extensive or specialty care requires preauthorization from MMSO prior to initiation. These conditions may be referred to an MTF for evaluation or treatment prior to authorization. This category includes, but is not limited to crowns, bridges, veneers, implants, surgery, and temporomandibular joint dysfunction (TMD) treatment. For extensive or questionable treatment plans, an evaluation by a military general dentist or specialist may be required before authorization is given.

(b) Civilian Orthodontic treatment is not normally authorized (other than reasonable minor tooth movement). Exceptions are made only when a military orthodontist specifically recommends treatment as necessary to maintain the health of the member (documented as not elective or for cosmetic purposes). Orthodontic treatment may occasionally be approved in support of orthognathic surgery performed in an MTF when the military orthodontist and surgeon have concurred with the civilian treatment plan in the GSU as being in the best interests of the patient.

(c) Authorization of periodontal surgery and implants to replace multiple missing teeth generally requires the evaluation and recommendation by a military periodontist or prosthodontist, respectively. This requires referral to a military dental clinic for evaluation prior to authorization of care.

4. Other Unauthorized Expenses. Medications for home use, toothbrushes, and other over-the-counter personal hygiene supplies, even if recommended by the dentist, are not authorized for payment. These are the personal responsibility of the service member.

C. Procedure for Requesting Prior Approval

1. To request preauthorization for specialty care, the service member's unit forwards written correspondence and supporting documentation to MMSO. The unit's commander or designated medical program representative should sign the request. Attachment 3 is provided as an example, and includes the information most helpful in processing the request quickly. X-rays or photographs that are submitted as supporting documentation will be returned with a letter providing an authorization number for the approved amount, or a recommended alternative or reason for denial.

2. While every consideration is given to minimize travel costs and the ADSM's time away from the command, this program is designed to augment, not replace those resources responsible for maintaining military dental readiness. Each Branch of Service requires periodic Type 2 exams by a military dentist to document dental readiness. Requests for civilian dental care can more accurately and consistently be determined with reference to the last military exam documented on the SF 603 from the ADSM's dental record. This also provides better management of dental readiness by the remote unit. If ADSM's keep this up-to-date by proactively scheduling exams when they are traveling to military bases for other purposes (personnel actions, HIV testing, etc.), requests can be approved more quickly, and travel costs are better managed.

3. When in doubt about prior approval requirements or procedures, MMSO may be contacted for further clarification at 1-888-MHS-MMSO. The point of contact for administration of this program is the MMSO dental officer, who can also be contacted at DSN 792-3950 or (847) 688-3950.

D. Filing Dental Care Claims.

1. Once authorized care is received, the service member should obtain from the dentist an itemized invoice of procedures provided. The use of the standard American Dental Association (ADA) insurance form, which shows the dentist's payment information and Tax ID Number, dates of treatment, ADA procedure codes, and amount billed, speeds the processing of the claim significantly. If the dentist does not provide this information, claim processing may be delayed.

2. The itemized invoice should be submitted promptly to MMSO with a MMSO Claim Form (available on the MMSO web page: http://navymedicine.med.navy.mil/mmso) signed by the service member and the unit commander or medical representative. Upon receipt of an acceptable claim for emergency treatment, routine care within the prescribed thresholds, or preauthorized specialty care for an eligible service member, MMSO will process the claim and issue payment directly to the dentist.

3. If the service member has paid out-of-pocket for dental care, a Standard Form (SF) 1164, Claim for Reimbursement for Expenditures on Official Business, signed by the service member making the claim, and proof of payment must be submitted together with the dentist's itemized invoice and claim form as described above (SF 1164 is available from the Federal Supply System through normal supply procurement procedures and on the TRICARE Prime Remote web site (http:tricare.osd.mil/remote/)). Upon receipt of an acceptable claim for reimbursement, MMSO will process the claim and issue payment directly to the service member.

4. The address for submitting claims is:

Military Medical Support Office
PO Box 886999
Great Lakes, IL 60088-6999

5. It is the responsibility of the service member submitting the claim to ensure that procedures are completed and payment is credited to his or her account. Failure to obtain required authorizations or to submit the claim promptly may result in credit problems or even personal financial liability. When in doubt about procedures, if assistance is required, or to check on the status of a submitted claim, MMSO Customer Service can be contacted at 1-888-MHS-MMSO.

E. Dental Care Appeal Procedures**.** When MMSO denies a claim or written request for prior approval, the member or member's command will be notified promptly by letter. The member or member's command may mail or send a facsimile letter with additional information as an appeal. Level I appeal represents the initial adjudicating authority. Any level in the appeal process may overrule the previous decision and order payment or approval of the request in whole or in part. Appeals must be made in the following sequence to the appropriate level as outlined below:

1. Level I: Officer in Charge, Military Medical Support Office, PO Box 886999, Great Lakes, IL 60088-6999. FAX: DSN 792-3905, or (847) 688-3905.

2. Level II: Chief of the Dental Corps or Designee for the service member's branch of service.

3. Level III: Surgeon General of the service member's branch of service or Designee (final level of appeal).

F. Contact Information.

1. These instructions and forms, as well as other information about MMSO may be found on the MMSO Web Page at: http://navymedicine.med.navy.mil/mmso/

2. A Customer Service representative may be contacted at **1-888-MHS-MMSO** (888-647-6676) for general information or questions pertaining to claim processing or status of a claim.

3 The dental division of MMSO may be contacted by phone at the same number, or DSN 792-3950, or (847) 688-3950 for further information about requesting a prior approval.

4. The point of contact for administration of this program is the MMSO dental officer, who can also be contacted at DSN 792-3950 or (847) 688-3950.

VI. Enrollment Transfer. ADSMs are responsible for ensuring their enrollment information is kept up-to-date. Upon arrival at a remote unit, an ADSM must take action to initiate enrollment in TPR (and consequently to ensure enrollment status is transferred from their previous region, if applicable). Service members departing a remote site should remain enrolled in TPR until they arrive at their new duty station. Upon arrival at their new duty station, ADSMs must again ensure that they transfer their enrollment to their new location. This is accomplished by visiting or calling the nearest TRICARE Service Center at their new location.

VII. Beneficiary Education

A. Educational activities in the TPR Program will be shared. The subparagraphs below outline primary and secondary responsibilities under this program.

1. TMA will:
   (a) Produce the following educational materials and distribute these materials to the Services, Lead Agents, MMSO and contractors:
      (1) TPR Pre-enrollment Brochure.
      (2) TPR "Remote Controller" (Enrollee Handbook)
   (b) Obtain unit listings of remote site units from the Services and share these with the Lead Agents.

2. The Service Surgeons General will:
   (a) Assist TMA with identification of remote site units.
   (b) Coordinate with their Reserve Components on this program.
   (c) Review all materials related to the program.
   (d) Serve as the final approval/disapproval level for all ADSM appeals under this program.

3. The Lead Agents will:
   (a) Provide MCSCs with listings of remote site units in their regions. These unit listings will be updated as needed, and new lists provided to the contractor.
   (b) Direct that MCSCs perform educational sessions as needed.
   (c) Assist with outreach and education to units and individuals.
   (d) Review all materials related to the program.

4. The managed care support contractors will:
   (a) Distribute TPR educational materials (both government and contractor produced materials)
   (b) Perform educational sessions at the direction of the Lead Agent.

(c) Develop enrollment forms and provider education materials to support the TPR program. Provider educational materials are the responsibility of the MCSC in accordance with MCS contract provisions related to marketing and education activities. Standardized marketing materials, developed by the Government will also be included in materials distributed by the contractors.
(d) Review government materials related to the program.

B. If capacity for enrollment exists in an already established contractor network, education and enrollment materials on the TRICARE Program shall be provided upon request to other beneficiaries who reside in the TPR area.

VIII. Special Programs

A. Alaska

1. The TRICARE Pacific Support Office, Alaska will be responsible for network development and other functions involved in the management and oversight of the TPR Program in Alaska, which are not included in the scope of work for the MCSC for Regions 9, 10, and 12.

2. The MCSC shall provide administrative services and support for this program according to the provisions of the current contract (e.g., TRICARE Service Center support, claims processing, etc.)

B. Overseas

TRICARE Europe, Latin America and Pacific Lead Agents will manage remotely assigned personnel in overseas locations apart from this program. Overseas initiatives will be tailored to the unique environments in each locations.

ATTACHMENT 1: US COAST GUARD SERVICE POINTS OF CONTACT

Regions 1, 2, 3, 4, 5, 6 and Central

Commander (KMA)
MLC Atlantic
300 East Main Street
Suite 1065
Norfolk, VA 23510-9110

Phone: (757) 628-4345

Regions 9, 10, 11, and Pacific (Alaska and Hawaii)

Commander (K)
MLC Pacific
Health & Safety Division
Coast Guard Island, Building 54-B
Alameda CA 94501

Phone: (510) 437-3487

ATTACHMENT 3: SAMPLE PRIOR APPROVAL REQUEST

[COMMAND LETTERHEAD]

From: [Command Name, etc.]
To: Director, Military Medical Support Office, PO Box 886999, Great Lakes, IL 60088-6999

Subj: REQUEST FOR PRE-AUTHORIZATION OF CIVILIAN DENTAL CARE ICO [NAME, RANK, SERVICE, AND SSN OF INDIVIDUAL SERVICE MEMBER]

Encl: (1) Copy of Civilian Dental Treatment Plan
(2) Dental x-rays and/or photographs
(3) Copy of dental record (SF 603's) [showing last military T-2 exam]

1. Pre-authorization is requested for civilian dental care indicated by enclosures (1-3). We understand that any authorization is for this request only, and may not apply if the information provided changes.

2. This service member is on Active Duty [or other DEERS eligible status]**. The following information is provided:**

a. Total estimated cost of this treatment:
b. Date of last military dental exam:
c. Service member's duty location and work phone number:
d. Date assigned to a GSU (geographically separated unit):
e. Projected Rotation Date:
f. Expiration of obligated service:
g. The nearest Federal/Military Dental treatment facility: [Name and distance - Include VA medical center with dental sharing agreement, if known]

3. My point of contact is [NAME, RANK, PHONE NUMBER OF COMMAND'S MEDICAL REPRESENTATIVE, HBA, OR OTHER KNOWLEDGEABLE PERSON]

[SIGNED BY COMMANDER OR DESIGNEE]